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• 中文關鍵字	中風；登錄系統；危險因子；；；；；		
• 英文關鍵字	stroke；registry system；risk factor；；；；；		
• 中文摘要	中風是國人十大死因的第三位，也是成人殘障的第一要因，更是使用健保資源前三名的疾病，以往國內並未有大規模的中風住院病人登錄系統，故無法推論出台灣地區的現狀，以評估中風病人之醫療品質。 有鑑於此，本計畫已在台灣腦中風學會的理監事會徵得同意，代表腦中風界整合 40 家涵蓋不同層級（醫學中心、區域醫院、地區醫院）之醫院，建立四萬人以上的大型中風登錄資料庫，而 97-98 年新增 15000 名登錄病例之目標亦已達成。依據此登錄資料庫進行分析，發現出血性中風患者出院死亡率較缺血性中風患者高，蜘蛛膜下腔出血患者之出院死亡率最高(17.2%)，其次爲顱內出血患者(10.8%)；缺血性中風患者以第三個月復發率最高(1.2%)，暫時性腦缺血發作與蜘蛛膜下腔出血患者則以第一個月復發率最高(1.2%，1.9%)，顱內出血患者以第六個月最高(0.6%)。比較中風後之預後情形發現預後較佳者有較高比例有定期回診，預後較差者，未定期回診比例偏高。針對醫療資源使用情形，主要治療用藥及出院用藥皆爲抗血小板藥物，使用比例佔八成以上，住院治療中之處置方式，則以復健爲主，佔四成以上。至於影像設備，不論醫院屬於哪一個層級皆主要以電腦斷層掃描來確診中風。評估中風類型、缺血性中風亞型之危險因子分布情形，結果顯示不論哪一型之中風，高血壓及運動量不足均排名在危險因子前五名中。 未來要永續經營中風登錄系統且推廣至全國，建議可朝向成立各醫院中風中心及設立評鑑系統的方向規劃，當登錄醫院數量達到一定之規模後，將登錄工作列爲健保給付之規定，而透過成效給付計畫，則可給予中風照護品質績效優良之醫院獎勵，而對於醫療資源較缺乏之地區，可考慮與遠距醫療結合，重新整合照護體系，將中風所造成之失能降至最低。		
• 英文摘要	Stroke was the third leading cause of death and the first cause of adult disability which caused social impact severely. It is also the		

first three high spending in the National Health Insurance resource. In the past, there was no large-scale stroke registry system in Taiwan. Therefore, it is difficult to evaluate the stroke profile and the quality of stroke care in Taiwan. In order to evaluate the stroke pattern and quality of stroke treatment in Taiwan, a study on setting up a multicenter stroke registry system including 40 hospitals with different scales (medical center, regional hospital, and local hospital) was carried out by Taiwan Stroke Society. A total of more than 40,000 stroke events have been registered in this database. The objective of registering 15000 stroke events between 2008 and 2009 was achieved. After data analyses, we found that the in-hospital mortality in ischemic stroke was higher than that in hemorrhagic stroke. The highest in-hospital mortality was seen in the subarachnoid hemorrhage (SAH) (17.2%) and the second high was intracerebral hemorrhage (ICH) (10.8%). The highest stoke recurrence rate in ischemic stroke was at 3-month post stoke (1.2%), transient ischemic attack (TIA)(1.2%) and SAH (1.9%) at 1-month post stoke, and ICH at 6-month post stoke (0.6%). Comparing to the stroke cases with worse outcome at 6-month post stroke, the percentage of regularly revisit to clinic was greater in those with better outcome. The major medicine during hospitalization and discharge was antiplatelet with more than 80% utilization rate. The major clinical treatment during hospitalization was rehabilitation with more than 40% utilization rate. The majority screening tool for stroke cases was computed tomography in all participating hospitals. No matter in which stroke type or subtype, hypertension and physical inactivity were in the first five risk factor. Several ways were suggested to keep the stroke registry system for long-term operation and to promote the registry system nationwide, such as (1) to establish a stroke center in hospital and quality indicator project in stroke care; (2) to recruit quality indicators of stroke care in the project of pay for performance and only the hospitals with good quality of stroke care will have payment. For the area lacking of medical resource, telemedical systems can be considered to involve in the stroke care system to reduce the disability due to stroke.